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Abstract

Global health partnerships (GHPs) are the conceptual cousin of partnerships in the development sphere. Since their emergence in the 1990s, the GHP mode of working and funding has mainly been applied to single-disease, vertical interventions. However, GHPs are increasingly being used to enact health systems strengthening and to address the global health worker shortage. In contrast to other critical explorations of GHPs, we explore in this paper how the fact, act and aspiration of *binding* different actors together around the ideology and modes of *partnership working* produces the perpetual state of being *in a bind*. This is an original analytical framework drawing on research in Sierra Leone and London. We offer new insights into the ways in which GHPs function and are experienced, showing that along with the successes of partnership work such arrangements are often and unavoidably tense, uncomfortable and a source of frustration and angst.

Key words:

Global health, partnership, Sierra Leone, development, health systems strengthening

The Binds of Global Health Partnership: Working Out Working Together in Sierra Leone

Introduction

How do we work in partnership, like real partnership? Not just lip service and go off and do what we want, but actually do it so that our partners are leading? (L29)

“Partnership” has a relatively long history in relation to the ideologies and modalities of development assistance (Harrison 2002; Mercer 2003), but its proliferation as a *modus operandi* of the global health sphere is more recent (Brown 2015; Gerrets 2015; Herrick 2017a). Given their ubiquity, GHPs have understandably been met with varying forms of analysis and critique, focusing on how they are a ‘contested process’ (Mercer 2003, 744) and a ‘murky space’ between theory and practice (Brown and Prince 2016, 12; Brown 2015; Crane 2013; Wendland 2016). Some have argued that partnerships reproduce power differentials between northern and southern partners (Crane, 2010; Geissler 2013; Harris 2008), while others have explored how they produce new forms of agency and discipline (Abrahamsen 2004, 1454). Alongside these qualitative engagements, efforts to categorise, systematise and measure “what works” in partnership arrangements continue apace (Department for International Development 2016).

This paper builds on these bodies of work by asking how volunteers, staff members and the diffuse amalgam of partners that compose one particular GHP narrate and reflect upon their experiences of *working in partnership*: what it means, does and enables, as well as the barriers and complexities it creates. This case study is of one organization, King’s College London’s Sierra Leone Partnership (KSLP) established in Freetown in 2011, that rose to international fame for its Ebola response in 2014/2015 (Johnson, et al. 2016). Much has been written about this partnership in the context of this humanitarian emergency (Brown, et al. 2016), but little

has been written about its transition back to its original HSS mandate to address the state of “*normal* emergency” (Feierman 2011) that characterises the Sierra Leonean healthcare landscape.

We use the example of KSLP to argue that partnerships create and therefore function as a “bind” in two, contradictory senses. First, bind is a *verb* that reflects how partnership work ties different actors together through the values of cohesion, commitment and collaboration towards the achievement of common goals. Second, bind is a *noun* in the sense of being a conundrum or a problematic state of affairs; to be in a bind is to be caught in a predicament for which there is no easy solution and certainly no resolution. Indeed, as we will explore, the fact, act and aspiration of *binding* different actors together around partnerships produce the perpetual state of being *in a bind* as actors attempt to reconcile competing agendas and objectives. Being in a bind thus becomes the *de facto* mode of operating in partnership, generating a persistent state of angst as partners try to mediate between being true to the ethic of collaboration while addressing the vital needs that originally motivated (and continue to justify) the need for in-country engagement. As such, partnership arrangements are perennially “uncomfortable” (Geissler 2013, 23) even though the global health field continues to lionise them and their potential (Martin, et al. 2016).

Our work contributes to the cross-disciplinary understanding of GHPs as a new modality of development, and to the growing corpus of critical medical anthropological work on the experiences and politics of global health volunteering in hospitals of the global south (Brown and Prince 2016; Lasker 2016; Wendland 2010; Crane 2013). To explore what we mean by *the binds of partnership*, we first trace the emergence of GHPs in the broader context of partnership working within the development sphere. We then explain what KSLP is and does and the methods used in this research. Finally, we interrogate the binds of partnership through three

themes – 1) resources and responsibility, 2) capacity and 3) complexity – before offering some concluding thoughts.

Partnerships: From international development to global health

Partnership work emerged in the 1969 *Pearson Report* as a perceived antidote to the broadly defined unequal power structures of donor-beneficiary relations, the associated disempowerment of developing countries vis-à-vis their development priorities and as a way of making development assistance more palatable at a time of increasing scepticism over waste and corruption (Andersen and Jensen 2017). The notion of partnership put forward by the report promotes a vision of “good governance” (Abrahamsen 2004; Gerrets 2015) and argues that Southern countries should share in the design and execution of development priority-setting and program design, rendering all sides of the relationship accountable, empowered and responsible. Building on this ethic, GHPs stem from early efforts by the *Commission on Health Research and Development* (1990) and *The Global Forum on Health Research* (1996) to ensure that southern countries play a role in setting health research and programme agendas and priorities (El Ansari, et al. 2001; Geissler and Tousignant 2016). GHPs emerged in tandem with new global health funding mechanisms (i.e. the Global Fund, GAVI etc) and have most often been applied to single disease, vertical interventions to tackle HIV/AIDS, TB, malaria and child and maternal health (McGoey 2015). This has also meant that “dyadic relations between donor and recipient have been replaced with complex latticed arrangements that enrol numerous different participants through processes of partnership, participation, and stakeholder involvement” (Brown and Green 2017, 48). It is these “participants” and “processes” that animate this paper.

In the UK, GHPs have largely been deployed to achieve HSS objectives and to address the global health workforce shortage in a field known as Human Resources for Health (HRH)

(Herrick 2017a; Reid, et al. 2018; Wendland 2016). These ‘Health Partnership Schemes’ (HPS) have been funded by the Department for International Development (DFID) and, since 2006, managed by the Tropical Health Education Trust (THET) (Herrick 2017a). Between 2011 and 2017, DFID spent £30.2 million on HPS (Department for International Development 2016) and this commitment looks set to continue, given the World Health Assembly’s 2016 adoption of an “integrated” and “people centred” framework for Universal Health Coverage and the UN’s 2015 *Global Strategy on HRH: Workforce 2030*. GHPs can involve state funding agencies, government, universities, hospitals, primary care settings and NGOs. They may also entail sending a roster of global health volunteers from the global north to train healthcare workers in ‘partner’ institutions in the global south (Lasker 2016; Sullivan 2017a; 2017b; Wendland, et al. 2016). Here partnership is envisaged as both means and ends to achieving a more resilient health workforce in southern countries as well as conferring benefits on northern (or increasingly southern) partners (Benet et al, 2018; Herrick 2017a).

It is notable that just as “partnership has become a dominant modality for the bilateral engagements of international donors and aid agencies with governments of the global South” (Brown 2015, 345), concern has grown with the “difficulties in achieving ‘genuine’ partnership based on equality and mutual respect in a context where one party is in possession of the purse and the other holds only the begging bowl” (Abrahamsen 2004, 1454). What “genuine” partnership might be is a hard question to answer given that “the collaboration inherent in a partnership is more than a mere exchange—it is the creation of something new, of value, together” (El Ansari, et al. 2001, 232). What this “newness” and “value” might be is not entirely clear, provoking questions about how these new partnerships might repeat past problems of multilateral and bilateral aid. One certainty, however, is that GHPs are now a source of huge policy debate and significant monitoring and evaluation work. This work includes attempts to develop typologies of “effective partnership” (Buse and Harmer 2007), to evaluate “what

works” and to calculate the “value added” of partnership working (Kamya, et al. 2016). The overriding biomedical evaluative frame of quantification, metrics, indicators and outcome measures questioned by some (Adams 2016; Erikson 2012) stands in stark contrast to the everyday human performances that come to shape partnership working, including those that lead to varying degrees of “efficacy” in the multifarious (and hugely political) contexts of HSS and HRH (Andersen and Jensen 2017; Geissler and Tousignant 2016; Wendland 2016).

The idea that GHPs invoke (and obscure) inequality, power and performance and offer a “diversity of stated experiences and perceptions” (Moyi Okwaro and Geissler 2015, 501) have come to occupy the anthropological imagination through an engaging corpus of work. Some have examined the experiences of international medical volunteers (see Brada 2011; 2016; Brown 2015; Brown and Prince 2016; Sullivan 2016; Wendland 2010; 2016) and the partnership strategies deployed by southern researchers and scientists (Crane 2013; Geissler and Tousignant 2016; Moyi Okwaro and Geissler 2015). In these accounts, attention has often focused on the southern partners’ experiences rather than how *all partners* navigate the tense path between getting things done and staying true to the ethic of partnership. While it is still arguably the case that “partnership is one of the most over-used and under-scrutinised words in the development lexicon,” at the same time, “close analysis” of the meaning and experiences of partnership has animated much recent anthropological writing (Harrison, 2002: 589, 590).

Here we want to add a new frame to this emergent genre by pinning down partnership’s ‘slipperiness’ through an empirical exploration of how it both *binds* and creates *a bind* in the context of KSLP. Here, we explore how partnerships function as a moral field of action characterised by the aspiration of binding partners together in ways that not only help the collective achievement of project objectives, but also make real the otherwise ephemeral and unreachable vision statements of what partnership *should* be. Binding is both a means of

working and, in theory, an end in and of itself. But, the busy work of trying to bind partners together around common goals – often involving meetings, memos, phone calls, report writing - is often far easier to articulate than the higher order and fleeting moment when everyone is bound to a shared vision. When efforts to achieve means or ends fall short, as they invariably do in the Sierra Leonean context, partnership working (and especially this “busy work”) becomes experienced and enacted in ways that create a perpetual bind, a source of angst and frustration for those involved.

The King’s Sierra Leone Partnership

From its inception in 2011, KSLP has evolved into a multi-actor arrangement between King’s Health Partners (King’s College London, Guy’s and St Thomas’, King’s College Hospital and the South London and Maudsley NHS Foundation Trusts) and three Sierra Leonean partner institutions: Connaught Hospital, the College of Medical and Allied Health Sciences (COMAHS -- the country’s only medical, pharmacy and nursing school) and the Ministry of Health and Sanitation (MoHS). KSLP has a long-term national and international team based in Freetown and shorter-term team of skilled volunteers that help deliver certain programme-specific objectives and projects. Over 100 volunteers and staff have passed through KSLP’s doors to deliver on its “pillars”: Clinical engagement at Connaught; curriculum development at COMAHS, supporting the MoHS on HRH; and strengthening research capabilities. KSLP invokes the lexicon of many GHPs in its drive towards capacity building, embedding change, co-development, collaboration, mentoring and role modelling.

The story of KSLP can only be told alongside that of the West African Ebola outbreak in 2014 and 2015. When Ebola hit Freetown in May 2014, KSLP become one of the key partners in the national Ebola Response Consortium, a collective of NGOs brought together by DFID and the International Red Cross. While many NGOs fled, KSLP stayed at Connaught, repurposed

a ward as an Ebola Holding Unit and developing a systematic response to screening, diagnosis, isolation and treatment that allowed the team to see an estimated 37% of Freetown's cases (Johnson, et al. 2016). The outbreak presented a significant challenge to a country already suffering from grossly inadequate health infrastructure and staffing (Abdullah and Rashid 2017; Anderson and Beresford 2016; Kruk, et al. 2015) and some of the world's lowest life expectancies and highest infant and maternal mortality rates (Jain, et al. 2015). EVD was a humanitarian disaster, but it was also a watershed moment for KSLP, bringing funds, volunteers, prestige, awards and international visibility (KSLP 2016). It also solidified the partnership through new levels of trust and accountability between KSLP, Connaught and the MoHS. However, since being declared Ebola-free in 2016, Sierra Leone's health system challenges have only worsened. With an estimated 7% of healthcare workers killed during the outbreak (Evans, et al. 2015) and the country's medical schools forced to shut for nine months; the HSS remit of KSLP is now arguably even more important. KSLP has therefore transitioned between distinct phases in its short history: from its original healthcare partnerships, to emergency humanitarian and medical response, to a post-Ebola recalibration. It thus offers an important case study of GHP work as the experiences of the outbreak laid bare the stark contrast between the *modus operandi* of humanitarian emergency and the *long durée* of sustainable HSS work.

Our ethnographic research was undertaken between London and Sierra Leone. It included 40 semi-structured interviews with KSLP's past volunteers and staff in late 2016 in London and remotely through Skype (reflecting the international composition and career destinations of many volunteers). A further 30 interviews with KSLP's current staff, volunteers and partners were undertaken *in situ* during fieldwork at Connaught in early 2017 and 2018. We also undertook ward observations, informal chats and discussions in the hospital. Like many such studies (Sullivan 2016; Wendland, et al. 2016; Wendland 2016), our interviews were often

snatched during the rare quiet moments in interviewees' working days and, for many Sierra Leonean staff facing significant levels of research fatigue, reflective responses about partnership working were often hard to procure. Mindful that "inviting informants to discuss collaborative relations may threaten those relations" (Moyi Okwaro and Geissler 2015, 496), we made every effort to ensure that respondents felt able to freely talk about their experiences in confidence through assurances of anonymity and confidentiality.

In contrast to many qualitative studies of global health volunteering that have concentrated solely on doctors, medical students and volunteers on short-term placements (Crane 2013; Lasker 2016; Reid, et al. 2018; Street 2014), we interviewed the full spectrum of KSLP's volunteers and staff. This includes doctors and nurses in various specialisations (from general surgery, to trauma and infectious diseases), but also physiotherapists, educators, psychiatrists, operations and logistics specialists, engineers, fixers and lawyers that have worked in timespans ranging from a few weeks to many years. This professional spectrum dispels the notion of GHPs being solely biomedical in nature, a characterisation that many hospital ethnographies have tended to reinforce (Herrick 2017b). Indeed, as we explore, partnership itself is often created and sustained as much in back office endeavours of report and grant writing as it is in the frontline delivery of medical care and innovation, much to the horror of many of the medical volunteers we spoke to (cf Brown and Green 2017). Partnership is also reflective of particular combinations of people and moments in time with their attendant challenges and contexts and these necessarily evolve and change. Interviews were recorded, transcribed and anonymised. In the analysis that follows, interviews are coded as either being carried out in Sierra Leone (code: SL) or in London (code: L) and assigned a number. In the remainder of this article, we trace the notion of the 'bind' in relation to three areas: resources and responsibility, capacity and complexity.

i. Resources and responsibility

In theory, the responsibility for GHPs achieving their outcomes is shared across all partners and thus becomes one of the forces that binds them together (see THET 2018). However, our research revealed competing visions of what one informant called “the boundaries of the partnership” (L40). These were brought out most forcefully when exploring where ultimate responsibility lay for addressing the profound resource gaps that had motivated the foundation of KSLP. Interviewees were candid in their assessment of what Sierra Leone’s healthcare system lacked: drugs, equipment, technicians, doctors, nurses, formal pay systems, training, text books for medical students, facilities for practical teaching, a stocked library, laptops and reliable internet. Some of the absent resources were those “mundane material deficits” (Wendland, 2016, 417) that were only fleetingly available – i.e. gloves, IV lines and basic medications - as noted by numerous African hospital ethnographies (see for example Livingston 2012; Street 2014). Others, such as plumbing (taps, running water, showers, toilets), were far more significant in scale and precluded the full functioning of the hospital. As a result, another informant told us “there is a tension in that [Sierra Leonean] partners very much want tangible goods, they want consumables because they are not getting them from the hospital or the government” (L06). As a Sierra Leonean medical student put it, “without materials, you can’t do anything” (SL6). Yet, identifying lines of responsibility for the procurement of these goods became a bind for many at KSLP. As we will see, this bind produced an often-painful situation where competing needs and responsibilities were made visible. Delivering on project objectives and staying true to the ethic of *sustainable* partnership meant going beyond attending to resource gaps (or just giving supplies). At the same time, the need to ensure that projects could function (at least in the short term) and the clear state of need at Connaught meant it was hard to not just give partners the resources they wanted.

The problem of responsibility for procuring supplies was tied to a confusion over leadership, producing yet another bind. During the early days of the Ebola outbreak, KSLP was thrust into a leadership position at Connaught, as no other single agency assumed responsibility for coordinating action on the ground. The memory of this role lingered among partners even as ascriptions of leadership responsibility shifted back towards the MoHS. Thus, confusion over leadership inevitably led to a bind that one past KSLP staff member characterized as a “discrepancy between what the partnership says it is they do -- which is: ‘we’re partners, we’re capacity building, we’re not in charge’ -- and the perceptions that the [Connaught] nurses have in terms of seeing the partnership as very much in charge” (L34). The disparity between the view of some local Connaught staff that KSLP was still “in charge” post-Ebola (especially in the realm of resource delivery) and KSLP’s aspirations to share and devolve leadership such that, effectively no one was ultimately in sole charge was particularly marked among those involved in the partnership’s Infection Prevention and Control (IPC) and Water, Sanitation and Hygiene (WASH) projects initiated in 2015.

These projects aimed to improve Connaught’s basic infrastructure by reinstating taps, running water and introducing infection control training. For the training to be worthwhile, meaningful and actionable, however, the project partners also needed to procure and ensure essential supplies (i.e. gloves, cleaning equipment, bins, bin bags). While the headline number of workers trained in IPC is impressive (1556 across four different hospitals), KSLP staff on the project recounted the frustrations of trying to procure the equipment needed to make the project not just workable in the short term, but also sustainable in the long term:

The hospital didn’t have any bins, so all the waste was going in boxes on the floor – needles, clinical waste – everything was going in there. So, we bought clinical bins, the same ones we have in the NHS. Because we did that, we needed bin bags, and

the central medical supplies don't supply them to the hospital. Sometimes they do, generally they don't. So, we started supplying. We said we'll supply until this date and from then you have to find a way to provide them. They kind of ignored that and then they suddenly realised that they'd run out. We said we're not providing anymore. So, they came to us and asked us to provide them for a bit longer, and we did. That happened again, and they asked one more time. Then they started to manage to sort it out (L23).

The vision of partnership held by this KSLP worker contained the hope and belief that local partners had the capacity to accept responsibility for ensuring that new processes function even after the funding stream ended (Abrahamsen 2004). Taking over the seemingly simple task of procuring bags for waste bins might seem trivial, but minutiae like this became sources of a bind when promised bin bags repeatedly failed to materialise and the future sustainability of the project was jeopardised.

In many ways, unstated but expected assumptions about partnership and shared responsibility undermined efforts to reach training goals, creating a feeling of being in a bind for all parties involved. A cleaner trained in IPC could not, for example, fulfil their training in any meaningful way without a dependable, long term supply of disinfectant, mops and gloves. However, project budget lines meant that KSLP could not guarantee this supply over the long term and the cleaner had no capacity to acquire the supplies. Often necessary supplies were at the Ministry's stores, but they could not or would not be released because KSLP was assumed to have the project funding to supply the resources themselves, at least in the short term. But, funds for the supply of these resources were often not written into KSLP's grant budgets (or were under budgeted for) as it was understood by both KSLP and the funders that, as a *partner*, the MOHS was ultimately responsible for their sustained provision both during the project and beyond.

It is not surprising that when faced with the conundrum of either getting the job done or doing the partnership work – that is, taking time to work out who was responsible for what and making sure it happened fairly – KSLP staff and volunteers often felt simultaneously trapped by and bound to the partnership ethic. As this volunteer said, it is a question of “whether we should just implement something because that would be quicker, more effective, or is it worth spending that time building a partnership and working at it?” (L33). At the same time, Sierra Leonean partners often expressed frustration because they felt that KSLP had an obligation to act as a donor and provide what was needed to help them achieve the partnership’s project objectives and better conditions at Connaught. Their view was thus often that satisfying vital and immediate needs through the donation of much-needed resources was more important than the cultivation of long-term resilience and responsibility among partners. As one past KSLP staff member stated,

I think there’s a perception from local partners that ... we’ve got money on the project and that’s what we should be doing with the money. Our argument is just not interesting for them at all. It’s a lot more challenging to make things sustainable, that’s why a lot of people don’t do it. They say, X or Y are providing all of these things for this hospital, why aren’t you doing it here? And I just say, our budget is different and our way of working is different. But that’s really frustrating for them (L23).

When lines of responsibility such as those described above are blurred or inconsistent between NGOs, problems of accountability among partners arise. One example of this was in the project to rebuild and upgrade Connaught’s trauma centre. One KSLP person said, it “was difficult because you weren’t sure who was in charge, who had oversight and who to hold accountable for things that go wrong or things that go well” (L33). Without any clarity of responsibility, there was a paucity of accountability, but both were arguably essential to maintain the binds – i.e. the intangible networks of trust, goodwill and reciprocity - of partnership. The need to work with and within these binds of partnership also made it exceptionally difficult to render partners accountable for problems. Indeed, as one volunteer explained, “because you are working in

partnership you can't call them out on things because to be able to work with the system you have to have a good relationship. That was very difficult and frustrating" (L38).

While our observations of the accountability gaps emerging in relation to shifting sensibilities about responsibility echoes Brown's assertion that "the performance of good working relations was central to the success of partnerships" (2015, 348), our research shows that "the performance" of such relations does not necessarily make the ascription of responsibility or accountability any clearer. Such performances also do not help address basic resource gaps and may arguably facilitate and justify the abdication of responsibility for basic resource provision by the Sierra Leonean state (Abdullah and Rashid 2017). In many ways, therefore, the increasing dependence on GHPs to deliver services and training means that they risk becoming complicit in the further erosion of state capacity to deliver basic healthcare, one of the most serious and inextricable binds they face (see Anderson and Beresford 2016)

ii. Capacity

'Capacity-building' is one of the core aspirations of GHPs. Geissler and Tousignant (2016) note that the "capacity imperative" is hard to critique due to its status as an "undisputed good" and the very real difficulty in pinning down exactly what it means and involves. We argue that it is also complicit in the creation of the binds that characterise GHP work. While capacity-building is central to the HSS mandate of KSLP, it is worth highlighting that at least some KSLP leaders felt that "during Ebola, we stepped into an area of need and we pushed where there was a power vacuum and a knowledge gap and a *lack of capacity*, and that's how we were able to initiate so much attention" (SL08, emphasis added). In a sense, therefore, the profile of the partnership was elevated by the very lack of health systems and workforce capacity that made Ebola so deadly in the region (Kruk, et al. 2015). Still, in contrast to most emergency

responses (see Redfield 2013), the capacity-building ethos of KSLP was not lost during the outbreak:

Trying to build staff capacity during an emergency, for example, was one of the things we tried to do. We all worked on the unit together, we all worked clinically together but we were aware that we eventually had to hand this isolation unit over to the local staff and how do we do that during an emergency situation and not forget that? (L24)

Just how to build capacity post-Ebola, however, was not entirely clear. Again, Geissler and Tousignant highlight the scope of this definitional range: “a pragmatic strategy to improve wellbeing, an ethical commitment to fair and sustainable collaborations, or a political project to reverse long histories of spatial imbalances of power, knowledge and resources” (2016, 350). Capacity is most often framed as the soft skills of individuals rather than material resources, educational funding or institutional procedures that govern the self-efficacy of health workers (Wendland 2016). Building capacity is often then the result of a unidirectional transfer of skills, knowledge or training with the problem that, as the example of IPC discussed above clearly shows, “the skills taught in training may simply be impracticable or irrelevant in the contexts in which the trainees actually work” (*Ibid*, 421). As such, and as exemplified by most attempts to do so, defining “capacity” in a workable sense within the partnership remains exceptionally hard.

In KSLP’s post-Ebola recalibration, capacity building has risen in prominence and references to it were common among those we interviewed. Many of Connaught’s nurses worked as unpaid volunteers and for them “capacity” related to the practical problems with doing the job: lack of efficient transport to work, no money for lunch or tea, lack of authority to dispense basic drugs. These lacunae perpetually and professionally incapacitated them, placing them in a bind in which seeking out any *additional* capacity became hard work. Further problems

included the question of how to motivate local partners to participate in programs and training and the role of per diems in this effort. One Sierra Leone-based respondent noted that incentivising certain working practices in the name of capacity building can have unwelcome consequences:

You're training as a commodity, you can get financial gain from it and therefore everyone expects per diems. If we choose not to give per diems, nobody comes to our training. Our clinicians feel like they're wasting their time. If we do give them, we are feeding a system which commodifies training. We take the line that we don't pay per diems. It means that we have to be slightly more forceful in making people attend trainings and our participants are grumpier (SL07).

Per diems instrumentalise and commodify capacity-building efforts and may help explain the demand for extra training expressed by many Sierra Leonean respondents. They also illustrate a perennial problem with capacity-building: that it is both a requirement and moral obligation of partnership arrangements, but its practical undertaking is often complicated by competing views about how and why people should be capacitated and how/if they should be compensated for becoming so (see Wendland 2016 for what such "capaciousness" might be). Payment for attendance was viewed by many international donors as a necessity and included in project budgets. But, for those GHPs that didn't give out per diems – KSLP included - local attendees (attuned to the possibility of payment elsewhere) were understandably unhappy at a perceived devaluation of their time and the lost possibility of making up chronically poor (or absent wages). Many at KSLP found themselves in a bind largely because inconsistency in per diem payment across the NGOs working on the same project meant that trying to capacity build by establishing a culture of regular meeting attendance (and therefore sustained project "ownership") in the long term was incredibly hard.

Efforts to enhance local ‘research capacity’ in the field of infectious disease was another form of capacity building. One KSLP endeavor to do this was a partial response to Ministry concerns that during and immediately after Ebola the flurry of research grants that came into the country were neither developed with local partners, nor responsive to local needs or reflective of local capacity to carry them out. These were considered bad faith, “extractive” research partnerships that eroded trust (see Crane, et al. 2017) and yet were inevitable because the expertise and institutional arrangements required by funders were not yet found in Sierra Leone and the “pots of money didn’t necessarily relate to the health priorities” of the country (L37). For Sierra Leoneans, this situation was described as putting them in a bind, especially as the situation really undermined any sense of genuine partnership. One of the Sierra Leonean partners described it thus:

Now we’re post-Ebola, everybody is trying to develop grants towards strengthening capacity. You’re being approached over and over again, and it becomes very tiring. You start thinking, if all these grants are successful, how am I going to spread myself? But then you think, oh, I can’t say ‘no’ because you don’t have the luxury of saying no because ... it’s not something that’s common within the medical school to have research grants. You know, we’re not at that level yet (SL19)

What troubled this partner was that there was fundamentally a *lack of capacity to capacity-build* in Sierra Leone. This was further exacerbated by two issues. First was the demand on the part of many funders to have a southern partner. In the UK having a local partner was essential to be compliant with the regulations of Overseas Development Assistance (ODA) grant money and for fulfilling the capacity building criteria of such grants. Second, the difficulties in capacity building were exacerbated by the exceptionally short lead-in time for cultivating these partnerships for an increasing number of responsive mode grant schemes. For example, the

Global Challenges Research Fund grants administered by a collection of UK Research Councils, part of government's ODA commitment and highly prized by UK universities has turnaround times from calls to submission of a matter of weeks for millions in funding. This leads to binds like the following:

With the first grant, it was almost like an after-thought to get the medical school involved because everything had been developed and then, 'oh, we need to have a partner in-country.' So there was not enough time to fully commit to the proposal and see what we wanted to get out of it. We needed to rush things because at the end of the day, we wanted to be part of the partnership. So, I think it would be better if we engaged with... the research context or the research gaps there are. We're trying to address those to ensure that whatever we're engaging in is sustainable and beneficial (SL19).

While the will to work in partnership is clearly strong, it is ironic that the partnership's grant successes may constrict the existing capacities of Sierra Leonean staff. The short grant timescales also preclude the organic evolution of projects from the partnership's shared conceptions of local need. This predicament forms a double bind for participants on both sides. The binding together of partners as Investigators on grant applications forms a bind for those over-stretched in-country partners who are needed to legitimise project applications. For the northern partners, the recognition that without sustained grant money the partnership cannot operate also creates a bind.

iii. Complexity

In our final example, we focus on the notion of complexity to explore how GHPs create not just bonds but also binds for partners. In contrast to single disease, vertical interventions, HSS work is arguably far more multi-dimensional and complex as it necessitates, in theory at least,

the tackling of multiple health and healthcare problems simultaneously. Yet, the complexity of health systems means that strengthening them is generally unsuited to the siloed fixes that tend to emerge when GHPs are funded through a multiplicity of individual project grants. As our research shows, working project by project provoked feelings of futility, resignation and created binds when faced with a revolving door of volunteers and staff and the concomitant need to address problems holistically and sustainably through partnership. For KSLP, this played out in three interlinked ways that we explore below: managing the expectations of short term volunteers; dealing with the complexity of local systems; and managing the idiosyncrasies of a multitude of local partners.

Like many partnerships, KSLP's volunteers can be in country for a relatively short time. While some staff (both local and expatriate) had been in post for many years, short term posts were an unavoidable reality for unpaid positions that required time off from busy work and NHS training schedules. However, partnerships require long-term commitment to build in-country trust. The tension between the kind of embedded long-termism needed to cultivate trust (DFID 2016) and a funding and recruitment landscape that made this all but impossible created a real bind for KSLP. This was further entrenched when short-term volunteers arrived at Connaught and offered up what they perceived to be simple solutions to problems that also seemed, at first glance, to be simple. This often irked those who had been in-country for a while and for whom problems became increasingly complex as time had worn on. As one sceptical long-term volunteer stated, "nothing is simple, there is not a single solution to a simple problem" (L04). This situation often required uncomfortable conversations with volunteers in a bid to manage expectations:

We would have a new batch of people come in and every single person would want to do something new... to make their mark on the hospital. Sometimes it was just

like, look just chill out, sit back, take a week, watch how things are. Don't come in there and say, "well this needs changing and this needs changing". Just pause, look at what is around you, look at the country, the context, the history, get to know people first. Get to know who you can trust, who you can talk to, who has got what motive. Because most people have the best intentions when they start, but the more promises that get broken, the more stories that people tell to try and justify things, it pisses people off (L06)

For many KSLP staff then, managing the expectations of new arrivals while conveying the importance of the holistic thinking required by HSS work was a perennial challenge. It was also one that placed them in a difficult bind as they sought to cultivate and encourage enthusiasm for the difficult task ahead without crushing morale as they endeavoured to make volunteers aware of the real limits to making change in dysfunctional systems. These efforts also brought home the problems of strengthening health systems in contexts where many of the underlying causes of dysfunction lie not just outside the scope of projects, but the ethical and practical remits of the partnership itself. This was something that, as time went on, became painfully obvious to long-term staff, creating a bind where it was felt that action in one domain of a complex system might well be nullified by the inability to act in others:

It is difficult to prioritise in the situation in Sierra Leone because everything needs to be fixed. And everything... most things are dependent on other things so you kind of think, well there is no point me just fixing this because if I train the staff how to do it, there is no point because the drug supply is not there, so we have to work on both. There is merit to the holistic approach but then there is also the challenge of it. It is too much all at once (L06)

Working holistically to embed change within complex systems is immensely time-consuming and slow. It is thus hard to accomplish in a funding landscape that rewards fast responses, short-term projects and for which “complexity” exists only as an evaluative get-out clause. For those on the ground, the reality is the need to work within and navigate systems that are neither fast nor efficient. One KSLP staff member expressed disbelief that they’d spent six months discussing “how we can get a form printed for each patient who comes into the hospital. It’s taken us over two years and we’ve now finally got one piece of paper printed and in the system which will be sustainable. That’s pretty painful” (SL07). The slow pace needed to navigate these complex systems and build change was well exemplified by the project to rebuild the Connaught emergency department from 2015-2016. Here the gulf between the ease with which “partnership” can be written down as a means and end of a grant application and the often-painful, complex reality of its execution was not just palpable, but also acted as a bind. As one staff member recounted, “obviously, I needed to get buy-in from everybody, and ... initially at a meeting at the hospital they’d agree to something, then suddenly someone would say, well we don’t know about it, then you have to have another discussion with them and then go up to the Ministry level” (L18). Working with complex organisational structures composed of individual physicians, hospital departments, managers and ministries, as well as pleasing funders, meant that the process was unavoidably slow. However, the delays also ended up being fortuitous as they inadvertently provided the time and space needed to “speak to the right people at the Ministry of Health to show them around, explain the concept etc so that they were all on board with the project” which meant that “we’ve had absolutely no complaints about it, which is amazing” (L18).

The delay was precipitated by problems with the most immediate partner in the rebuilding project which led to a significant amount of reflection about the value of the project in partnership terms:

This project has been amazing but I think it's been seen by the hospital as done by King's and by me. But if it had been driven by [a local Sierra Leonean lead] I think it would have moved forward. There was definitely a question at one point where we said, 'Okay, we don't have a partner. Should we really be doing this work at all?' But...we realised that all the nurses are our partners, the Community Health Officers are our partners, and we have a duty to work with all of those partners, to make their lives better (L18)

Partnership is an exceptionally fragile and complex entity not least as success is contingent on the vagaries of the personalities needed to take local ownership of a project, "strongly champion" for it at higher levels and assume the necessary responsibility for it to become "resilient" and sustainable (Bradley 2008; Low, et al. 2003). This is an additional layer of complexity which project applications and timelines could neither predict or reflect and which short-term volunteers found harder to grasp, but which served to create real binds for those involved. For example, as one KSLP staff member mused:

There were some partnerships... where a lot of time and investment was put into individuals, which seemed to bear fruit. But, the downside of there being such a limited number of individuals that you can put this time into is that you can position them as an expert in a way that has outstripped their ability to have expertise...You might take somebody who is a very promising clinician and before you know what's happened he's actually the government spokesman (L30).

The best-intentioned partnership work can thus have the unintended effect of undermining any HSS gains by precipitating the loss of much-needed medical staff to senior government or more lucrative NGO posts. This is an example of where well-intention action in one aspect of a complex health system (or with one strategic partner) can have unforeseen, negative consequences down the line. For those in the partnership, trying to “do good” amid a fragile and volatile health system elicited understandable frustrations and resignation. As neatly summed up, “it takes time to sit alongside somebody and it takes a particular mind-set to sit alongside somebody while you can see things are going wrong” (L30). Such strategically selective amnesia is a defining element of the binds of partnership and occupies an unpalatable grey zone absent from the overt critiques of partnerships as exploitative and the more romanticised visions of partnership as “accompaniment” (Farmer 2011).

Conclusion

As we have explored in this paper, the ‘smoothness’ offered by ideal models of collaborative partnership (Buse and Harmer 2007) is often at odds with the ‘uncomfortable’ reality of the experience of trying to make them work (Geissler 2013, 23). This is not to denigrate the positives of partnership working and the undeniable achievements of so many GHPs, KSLP included, but rather to get beyond an obvious critique centred on why the “rosy idea of what a partnership is” (L33) in theory does not match the messy reality of practice. Instead, we have examined partnership as “modes of relating” (Brown, 2015, 349) which clearly involve interpersonal conflict, frustration and soul-searching about whether it might ultimately be simpler “just to upgrade everything physically and give them a boost” (L17). This was at odds with the nagging acknowledgement that “the partnership approach, it’s obviously, incredibly collaborative but the whole point is that we don’t just go in and do things” (L24). Volunteers

and partners found themselves in a bind when the need to work collaboratively could not keep pace with the compulsion to enact change. These were binds for which there was no clear resolution, only the continued faith in the ethic of partnership working.

The overarching bind of partnership for many respondents was that not being able to go in and get on with making the changes that seemed so immediately necessary went against the compulsion to help that had driven many to work for KSLP in the first instance. To have to work slowly together or, as Wendland puts it, “invest more in the messiness of human relationships than in the fantasy of magic bullets” (2016, 181), was far harder than many interviewees ever expected and created significant inner and actual conflict between partners. As one medic expressed,

To start with I was thinking, ‘Well, why are we tolerating this? There’s a lot of money within King’s and within the UK medical community that could be poured in to this.’ But I guess it’s the sustainability aspect of it, and that’s probably the big thing that I had to get my head around and change (L21)

Staying true to the ideology of partnership thus often involved tolerating situations that could just not be “fixed”. This is the kind of moral and practical bind that the expanding literature on GHPs has yet to critically grasp, most likely as articulating such situations can be exceptionally hard even for those who have experienced them. In working with the frustrations of “knowing the simple solutions and what could make a difference but not being able to do that because you don’t want to impose something and you don’t want to take charge because you want to collaborate with individuals on the ground, make sure they take responsibility and are supported in what they want to achieve” (L33), many participants felt torn between their belief

that working in partnership was the “good” and “right” thing to do and their sadness at not being able to effect the kinds of changes they felt were so obviously needed.

Partnership working, the sustainability ethic that underpins it and thus the inability to fall into the straightforward donor role demanded by local partners often provoked some powerful existential questioning. As one respondent pondered, “I know development is about empowering people to take the initiative themselves and you can’t just give a man a fish you have to teach him how to fish but... it makes you think, well actually what the hell am I doing here?” (L04). This kind of existential crisis was far more common among long-term staff and, among them, one reflection stood out: “You always have that thing in your head, would things be better if they were just left alone and people had to manage?” (L04). This is a captivating question that may be anathema to the interventionist logic and moral compulsions of global health but bears scrutiny. When partnership shapes the available terrain of action, the result is inevitably the kind of constricting moral and practical bind that led respondents to question their very presence in Sierra Leone. Yet, respondents never managed to elucidate a better mode of intervention and instead questioned whether intervention *tout court* was in the best interests of all partners. Experiencing partnership as a bind should not therefore be thought of as the wholesale failure of the model or one that demands some form of resolution. Instead, it offers a fascinating point of critical intervention to start to think about how these binds might start to be loosened in ways that allow different forms of mobility, action and change.

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